

*FlexAmerica*  
**Letter of Medical Necessity**

**Please include the letter of medical necessity with each claim filing**

This form should be completed by the attending physician to confirm treatment is medically necessary for a specific medical condition. Completing this form and requesting coverage for items specifically identified by the IRS as ineligible expenses, for example vitamins, will not permit reimbursement through your reimbursement account.

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**1. Enter the following information (please print clearly).**

Employer \_\_\_\_\_

Employee Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

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**2. Describe the diagnosed condition being treated:**

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**3. Describe the recommended treatment:**

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**4. Indicate the Duration of treatment:**

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**5. Read the following and sign / date.**

This treatment is medically necessary to treat the medical condition above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_